Medicolegal Aspects of EM

Duty of Care

Legal obligation to conform to a particular standard of conduct for the protection of others against unreasonable risks. This includes duty to remain current & competent in field of work.

Negligence

Negligence is based on there being breach of a duty of care where reasonable care (standard expected of the average practitioner of the class to which he belongs in those particular circumstances) has not been provided. The breach of duty of care must have been foreseeable & carry the likelihood of physical or quantifiable harm.

Good Samaritan Acts

Good Samaritan acts are not legally mandatory; however they may be morally, ethically or professionally obligated. Once done there is duty of care & thus subject to laws of negligence.

Medical Ethics

4 guiding principles:
Autonomy - the patient has the right to refuse or choose their treatment.
Non-maleficence - "first, do no harm".
Beneficence - a practitioner should act in the best interest of the patient.
Justice - concerns the fairness and equality of distribution of health resources
Also:
Dignity - the patient (and the person treating the patient) have the right to dignity.
Truthfulness and honesty

Mental Capacity / Competence

The ability to make an informed decision/have autonomy.
Must be able to:

- **Comprehend & retain** info (benefits, risks, alternatives) on proposed treatment and consequences of non-treatment
- **Believe** the information given
- **Weigh up** and reason a decision
- **Exercise free choice**.

In addition:

- A child <14y is usually not considered competant.
- A child 14-17 may be considered competant ('mature minor') if they can demonstrate sufficient understanding and intelligence to comprehend what is proposed and the attendant risks.

Risks for possible incapacity:

- Increasing age
- A relative identifying a lack of capacity
- Low educational attainment
- Depression
- Cognitive impairment.
- Abnormal behaviour or circumstances causing doubt about capacity
- Previous lack of capacity

Consent

- All patients have the right to choose and refuse a medical intervention, even if their decision does not appear to be in their best interest. For consent to be valid it must be:
    - Competent - the patient must have the maturity and capacity to make a decision
    - Informed - the patient must have sufficient information to make a decision
    - Voluntary - the decision must be an expression of the patient's free will.
- A patient has the right to withdraw consent at any time
- A 'mature minor' (see above) is not considered competent to consent to the **withdrawal** of life-sustaining treatment against their parents' wishes.
- Relatives cannot consent for another adult unless have valid Power of Attorney
- The person obtaining consent must:
    - Be suitably trained and qualified
    - Know sufficient detail about the intervention
    - Understand the risks
    - Follow the principles set out in relevant guidance.
- Written consent (although consent can be given verbally) should be obtained for:
    - Complex treatments
    - Participation in research programmes
    - Situations where patient understanding and explanation of risk requires clarification and confirmation
    - Particular types of treatment in order to comply with laws and codes of practice that govern these treatments, for example fertility treatment.

Refusal of Treatment

Often an ethical conflict of patient's autonomy and physician's beneficence.
Similar to consent, the patient can voluntarily refuse treatment at any time if he has:

- Been fully informed
- Mental capacity (as above)
- Reached this decision voluntarily

In addition, the patient should demonstrate he has ability to synthesise a decision – even if that decision is thought to be irrational.

Treating Without Consent

- If a patient temporarily lacks capacity - and it isn't possible to wait until they are able to consent - you must decide what treatment is in the patient's best interests
- Medical treatment can be provided to a non-competent patient without express consent in an emergency situation (implied consent), if the treatment:
    - Is limited to what is immediately necessary to save life or to avoid significant deterioration in the patient's health
    - Respects the terms of any valid advance refusal which is known about or drawn to your attention
- Getting a second opinion, documentation of justification may support implied consent.
- Mental Health Act provides for detention for Inv & Rx of only mental health issues in a mentally ill or mentally disordered patient, not for other investigations/treatments.
- Intoxicated patients may be treated under Duty of care/Implied consent.

Did Not Wait

Waiting time is the reason in >85% cases
Usually low acuity (only 50% seek review elsewhere, 5-10% subsequent admission rate)
Those who leave before expected triage waiting time:

- Sought alternate practitioner
- Decided complaint not important
- Not willing to wait

Those who wait beyond expected triage waiting time may have:

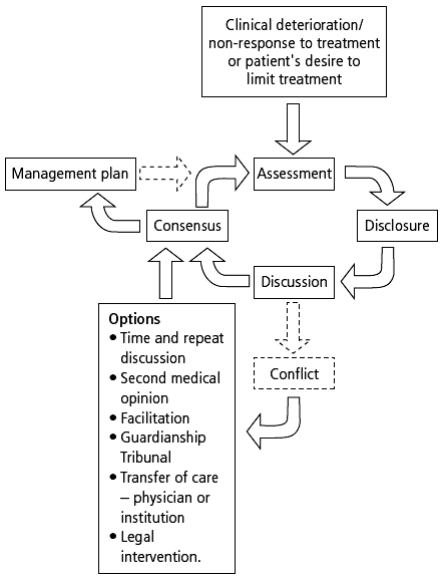
- Mental health issues
- Illness exceeds apparent severity (False negative triage)

Management of potential DNW/Discharge Against Medical Advice (similar if c/o ↑waiting times)

- Introduce
- Recognise/acknowledge concerns
- Assess
    - Problem severity/urgency – GP concern, repeat pres, high risk (CP, HI, fever, headache, paed, elderly)
    - Reason for DNW or DAMA (offer solution/uptriage if appropriate)
    - Mental state
    - Competence
- If under guardianship/other statutory authority →treat under the authority
- If mentally disordered or ill → consider treating under Mental Health Act
- If incompetent (incl intoxicated) → treat under duty of care/implied consent
- If competent
    - Encourage to stay
    - Explain situation/ED system briefly
    - Organise simple interventions : Find a bed/cubicle, observations, analgesia, fluids
    - Inform so can have realistic expectations of when will be seen/treated
    - If decides to go:
        - Inform potential risks of leaving
        - Advise re Mx post discharge
        - Follow-up / prevention – GP (inform), always can return to ED, home Rx, occ police if danger to self/others.
- Documentation – self-discharge form, medical notes.

Withholding or Withdrawal of Treatment

- These are equivalent legally and ethically.
- Not the same as euthanasia and assisted suicide (deliberate acts or omissions in order to end a person's life)
- Analgesia and sedation can be lawfully given in proportion with clinical need with the 1° goal of relieving pain or other symptoms, even if the medical practitioner is aware that the administration of the drug might also hasten death.
- Withdrawal of artificial hydration and nutrition, can be seen as any other treatment. Food & fluids by ordinary, non-medical means should be part of the care of dying patients as appropriate to their clinical condition



No CPR order

- The term No Cardiopulmonary Resuscitation (No CPR) order is preferred to Do Not Resuscitate (DNR) or Not For Resuscitation (NFR). Patient, or his family should be reassured that all comfort and other appropriate care will be provided.
- No CPR orders should be clearly written in the patient's medical notes as with other treatment decisions.
- Use of covert symbols on charts, medical notes or wristbands is not appropriate. In the absence of a clear No CPR order, resuscitation should be commenced until a senior doctor is available.

Advance Care Directives

- Excludes basic care of warmth, shelter, keeping clean, offering food or water by mouth.
- Invalid in suicide attempt.
- The directive must have been made by the patient voluntarily and while competent
- The directive is specifically applicable to the clinical circumstances that have arisen
- The directive must be sufficiently clear and specific to guide clinical care and there must be no suggestion that the directive does not reflect the patient's current intentions

In addition, it is best practice, but not legally necessary, that:

- The patient should periodically review the directive
- The directive should be available at the time decisions need to be made
- The directive should be signed and witnessed
- A medical practitioner should be involved in discussions with the patient

Confidentiality

Ethical, professional and legal obligation not to disclose to any third party any information acquired in the course of a professional relationship with the patient, without that patient's specific and voluntary consent.

Mandatory Reporting/Public Interest

Exceptions to confidentiality (statutory disclosures):

- Notifiable diseases
- Venereal diseases (STDs)
- Coroner cases
- Registration of BMD
- NAI
- Firearms legislation
- Impaired healthcare practitioner

If conflict of confidentiality & public interest (incl serious crime):

- Judgement on whether duty/danger to public outweighs duty to patient's privacy.
- If breach confidentiality then at risk of common law (but patient has to prove loss):
    - Breach of contract
    - Medical negligence
    - Defamation
- If doesn't inform Public at risk of:
    - Negligence if others suffer (failure of duty of care)
- Consult peers and Medical Defence organisation.

Coroner

Coroners ensure that all deaths, suspected deaths, fires and explosions in their jurisdiction are properly investigated (by inquest or inquiry) if necessary to ascertain:

- The identity of the deceased;
- The circumstances surrounding the death;
- The cause of death; and
- The particulars needed to register the death.

Deaths reportable by law to the coroner (for which no death certificate can be written) varies by state, but in NSW, is one where the person died:

- a violent or unnatural death,
- a sudden death the cause of which is unknown,
- under suspicious or unusual circumstances,
- having not been seen by a medical practitioner for 3mo,
- under, as a result of, or within 24h after an anaesthetic (excl LA in unsuccessful resus),
- within a year and a day after the date of any accident that may have caused the death,
- while in or on leave from hospital within the meaning of the Mental Health Act 1990,
- in custody or care, known to DoCS, or registered as disabled & receiving community care,
- with unknown identity.

Not all deaths in ED are reportable to the coroner. If the cause of death is known, not unexpected or the patient known to the ED/hospital then sometimes a certificate can be completed. Otherwise a GP may be able to write one, if appropriate, or refer to coroner.

Brain Death

Death may be mimicked by e.g. drug intox, sev Guillain Barre, hypothermia, locked in syndrome. Criteria for brain death (cessation of brainstem function) are prerequisite for organ harvesting. Strict requirements re personnel present & tests. Must be done >6hrs post-injury (so rarely in ED).

Requirements:

- Normal T (>35°C), BPsys (>100, <200mmHg), BSL, Na^+, pO2, pCO2
- Absent: muscle relaxants (normal train of four), sedatives, sig met/endo disturbance

Tests: [repeated 6h (child<5y: 12-24h) apart]

- Clinical absence of:
  - Corneal reflexes
  - Spinociliary reflexes
  - Papillary reflexes
  - Occulocephalic reflexes
  - Vestibulocochlear reflexes
  - Cough reflex – suctioning ETT
  - Response to pain
  - Response to atropine (no ↑HR)
  - Response to pCO2≥60mmHg (no ↑RR) – last test performed
- Other
  - Absence of cerebral blood flow on contrast CT or cerebral angiogram
  - Nuclear medicine scan showing no flow through ICAs & vertebral arteries
  - EEG flat for 30mins